

Dispatches from abroad: fighting maternal mortality in a former Soviet republic

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Tajikistan – Last month, 2 women died from complications of their pregnancy in the Karategin region of Tajikistan, a narrow valley that's home to a quarter million people in small villages dotted at the foot of looming, snow-capped mountains. Both women gave birth at home, with only untrained birth attendants present. It was the fifth delivery for one woman, the sixth for the other. Before delivery, both women were reported to be clinically anemic; after their deliveries, both had postpartum hemorrhages. One of the mothers was brought to the hospital but it was too late.

It is difficult to estimate a maternal-mortality rate in Tajikistan. The country, which borders Afghanistan, gained independence from the USSR in 1991. It has experienced a civil war and 3 changes in government since then. Health statistics are incomplete because most women have their babies at home and most families do not register the births — to do so costs approximately US\$1. With the average salary in Tajikistan being US\$2 to \$3 per month, it is not hard to explain the government's conclusion that the birth rate has fallen.

Recently, however, information was collected on maternal deaths as part of a maternal child care program implemented by Médecins Sans Frontières (MSF). The denominator (live births) was based on Soviet-era statistics, expected annual population growth and birth rates. Based on these figures, the estimated maternal-mortality rate ranges between 120 and 171 maternal deaths per 100 000 live births — 100 times the rate in countries like Canada.

This was not always the case in Tajikistan. As part of the Soviet Union — albeit the poorest member — Tajikistan had access to the Soviet system of free health care. During this time, the majority of women had their deliveries in hospitals, attended by midwives and obstetricians. However, 10 years after the collapse of communism and a brutal civil war, the health care infrastructure is in steady decline. Only international aid prevents complete collapse.

A recent maternal health survey conducted by MSF in the Karategin valley showed that 83% of women now deliver at home and 63% of all women deliver with an untrained attendant. Few women have antenatal care.

The challenge for MSF is to design and implement a project to improve the health status of women and newborns in a context in which overall poverty significantly

contributes to the underuse of available services and trained health personnel.

The World Bank reports that 80% of Tajikistan's population live below the poverty line. For a woman to deliver in a hospital, her family must transport her there, pay all the health personnel as well as the cleaner, bring their own sheets and food, along with coal or wood to heat the room, and supply all the drugs and medical materials. Many cannot afford all this. However, improving a country's economy is beyond the scope of a medical nongovernmental organisation, such as MSF. What, then, can be done?

It was felt that the strategy required activities that targeted different levels of care. First, we needed to improve the knowledge, skills and practices of those who attend home deliveries. This includes education of untrained birth attendants so they can identify high-risk pregnancies and the danger signs, plus refresher training for midwives. These seminars also aim to improve the communication between birth attendants and midwives to facilitate referral when needed.

Second, emergency obstetric services in hospitals need to be improved. This includes upgrading the maternity wards — ensuring adequate water and sanitation facilities, and providing the equipment required for complicated deliveries. Refresher training for physicians involved in emergency obstetrics is planned. In many cases, these doctors have not had any new medical information for more than 10 years. They still perform classical rather than lower-segment cesarean sections. According to the survey, one of the reasons why women do not go to the hospital is the perception that the quality of care is poor.

The program also addresses the need to increase community awareness about the preparation required for a birth. This includes setting aside money, purchasing essential materials such as clean razor, plastic sheeting and string for tying the cord, as well as arranging local transport in case complications arise.

The program, which started in March 2000, has a planning horizon of 2 to 3 years, so it is too early to see improvements. However, in talking with the birth attendants, midwives and doctors in the Karategin, I saw their eagerness to gain more knowledge and their commitment to provide good care to women despite the constraints they face. This is very encouraging.

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